June, 2000

The NEGP Monthly, Vol. 2 NO. 18

NEGP MONTHLY

A monthly in-depth look at states and communities and their efforts to reach the National Education Goals
Published by the NATIONAL EDUCATION GOALS PANEL

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The NEGP MONTHLY is a publication of the National Education Goals Panel.

1255 22nd Street NW, Suite 502
Washington, DC 20010;
202-724-0015
www.negp.gov

NEGP Executive Director: Ken Nelson
Publisher: Barbara A. Pape

HEALTHY CHILDREN

Children who are ready to learn are ready in a number of ways: socially, emotionally, cognitively. Being healthy may not be the first thought that jumps to mind when considering ready-to-learn factors, but in fact it is the foundation for all other building blocks of early education. Children who were born with low birthweight often have developmental delays. Children whose mothers used alcohol or drugs while pregnant sometimes have behavioral issues that make social and emotional adjustment difficult, at best.

The National Education Goals Panel monitors child health through the Children's Health Index. This Monthly examines what Massachusetts, Florida and Connecticut – top-performing states – are doing to pave the way for healthy births and children ready to learn.

Overview

Determining whether a young child is ready to learn has in the past centered on that youngster's cognitive and social skills. Is the child able to recite the alphabet? Can he or she count? Does the youngster know basic colors, share, work in groups and independently? Less common is an examination of the child's health. Yet, without good health, a child's success in school is severely limited.

In the absence of a direct measure of Goal One of the National Education Goals, Ready to Learn, the Goals Panel reports measures of the associated goal objectives, including children's health status. One indicator, the children's health index, monitors state performance on reducing the percentages of infants born with one or more of the following four health risks: mother received late or no prenatal care; mother made low weight gain; mother smoked during pregnancy; or mother drank alcohol during pregnancy. Reductions in these factors mean that

infants are more likely to be healthy.

A landmark study of kindergartners, *America's Kindergartners*, reports that physical well being or lack thereof can influence a child's social interactions and emotional development. "Children who have problems with their health or have lower levels of physical activity may feel lonely and less well liked by their peers," according to the report. "Children with developmental difficulties may develop feelings of separateness from their peers and adults other than their parents, potentially adversely affecting their school experiences." What seems purely beneficial to the birth and infancy of a human being – a mother who takes good care of herself during pregnancy – actually has repercussions as that child takes his or her first steps in the academic world.

Kindergarten in America

The Goals Panel has long sought a more direct measure of Goal One, that all children arrive at school ready to learn. This year the first results of a major new study of young children provides new data on this im[portant subject. Sponsored by the U.S. Department of Education's National Center for Education Statistics (NCES), the Early Childhood Longitudinal Study has issued the first report from this study, Kindergarten Class of 1998-1999, a landmark report on the status of children when they begin kindergarten. Researchers began following a nationally representative sample of some 22,000 kindergartners in the fall of 1998 and will continue to follow the children through the fifth grade.

"Whether or not children succeed in school is in part related to events and experiences that occur prior to their entering kindergarten for the first time," writes the report. These events include children's physical well being, social development, cognitive skills and knowledge and how they approach learning, all issues examined in the report.

Physical well being is essential and "may frame their learning opportunities – limiting or expanding them," notes the report. Researchers are monitoring children's physical well being based on the following indicators: height and weight, body mass index, motor skills, general health and developmental difficulties.

Happily, infants are being born with fewer of these health risks. Between 1990 and 1997, 37 states significantly reduced the percentages of infants born with one or more of the four health risks in the Goals Panel's Child Health Index. Eighteen states performed better than the United States average of 33 percent of infants born with one or more of the four health risks. This *Monthly* examines state programs and policies in Connecticut, Massachusetts and Florida that may have led to each state's success in boosting performance on the Children's Health Index. Representatives from all three states pointed to the Healthy Start program as a primary reason for their state's success in this indicator.

Typically a mother's level of education and whether they are on public assistance effects a child's physical well-being, which implies that programs targeted to disadvantaged mothers, like Healthy Start, are strong vehicles to improve children's health and readiness to learn.

Healthy Start

"Why are we moving so slowly toward better infant health?" queried Louis Sullivan, secretary

of Health and Human Services, at a 1991 press conference launching the federal Healthy Start program. "With all the federal, state and local programs that exist to support maternal and child health, why isn't America among the nations with the lowest infant mortality rates?" The reason Sullivan offered at the press conference is the nation was failing to "look at infant health through the most important set of eyes, the eyes of the young mother herself." Thus, the Health Resources and Services Administration of the U.S. Public Health Service launched Healthy Start in 1991. Access to care was – and remains – the linchpin to Healthy Start. The program also called for both providing resources and establishing model programs that work.

Healthy Start began with federally funded demonstration projects in about ten areas where infant mortality rates were especially high. The grants were awarded to initiatives that engaged a community-wide commitment and innovative approaches. Some of the program's intended results were:

- Put services where the need is. High infant mortality is often clustered in inner city or identifiable rural areas.
- Integrate services and provide one-stop-shopping. ("We need to bend our bureaucracies to fit the needs of those whom bureaucracy is supposed to serve," said Sullivan.)
- Tailor services to specific community need.
- Emphasize behavior change as well as medical care.

"One tenth of infant deaths can be traced to smoking, and some 10 percent of pregnant women are abusing drugs," said Sullivan. "If we're serious about impacting infant health, we must confront these behavior-related problems. We must help young women avoid, and when necessary help them confront and overcome, harmful addictions."

Massachusetts

Massachusetts was both one of the nation's most improved states and one of the 18 highest-performing states in reducing the percentage of infants born with one or more of four health risks. In 1990, 42 percent of infants were born with one or more health risks, dropping to 32% in 1997. The U.S. average in 1997 was 33 percent.

A report issued by the Massachusetts Department of Public Health in 1985 sparked the state's efforts to lower health risks for infants, explained Janet Leigh, a spokesperson for the Massachu-

setts Department of Public Health. *Closing the Gaps: Strategies for Improving the Health of Massachusetts Infants* offered five recommendations for closing the gap between advantaged and disadvantaged infants and families:

- Strategies to reduce low birthweight and infant mortality must be specifically targeted to and tailored for high-risk groups and areas.
- Maternity and infant health care must be affordable for all.
- Comprehensive maternity and infant care services must be readily accessible to all women in the state.
- Every woman of childbearing age should be well informed about factors contributing to healthy babies and about availability of services.
- Ongoing monitoring of maternal and infant health status and needs must be strengthened.

"We predated the federal Healthy Start program," said Leigh. "And as Medicaid has expanded, we have simultaneously expanded eligibility for Healthy Start."

A 1988 evaluation of the Massachusetts Healthy Start, three years after the program emerged, found the program "promotes early, comprehensive and continuous prenatal care for low-income, uninsured women in the Commonwealth in order to improve the health of their newborns by reducing the incidence of low birthweight and infant mortality." Women who participate in Healthy Start receive information and referral services, health education, advocacy, follow-up and care coordination through staff and a toll-free phoneline. Healthy Start staff are multilingual. They enroll over half the women on MassHealth, resulting in earlier access to prenatal care and other services for high-risk women.

Over the years, the Massachusetts Department of Public Health, which administers Healthy Start, has developed a continuum of programs and services for pregnant teens and women to "assure that all infants are born healthy and that all children are healthy and thriving in all areas of development." The programs combine state and federal funds and offer a coherent policy that targets the prenatal, birth and early childhood periods.

Leigh pointed out that all programs and services administered by the state Department of Public Health are designed and implemented at the community level. Most programs are administered in collaboration with other state agencies and federal programs, including Head Start, with the goal of preventing the duplication of efforts. Every effort is given to targeting high-risk families and communities.

Massachusetts also was a leader in the early 1990s for raising taxes on smoking, noted Leigh. Funds from the tax were directed to the Department of Public Health to run an anti-smoking media campaign and to develop smoking cessation programs statewide. Many of these programs were directed to pregnant women and teens.

CONTACT: Janet Leigh
Policy and Program Development
Bureau for Family and Community Health
Department of Public Health
250 Washington Street
Boston 02108
(617)624-6015

THE NATIONAL EDUCATION GOALS

Goal 1: Ready to Learn

Goal 2: School Completion

Goal 3: Student Achievement and Citizenship

Goal 4: Teacher Education and Professional Development

Goal 5: Mathematics and Science

Goal 6: Adult Literacy and Lifelong Learning

Goal 7: Safe, Disciplined and Alochol- and Drug-free Schools

Goal 8: Parental Participation

Florida

Florida also is both a top-performing and most-improved state in the Children's Health Index indicator. In 1990, 37% of the state's infants were born with one or more of four health risks, dropping to 29% in 1997.

State officials cite Florida's Healthy Start program as a primary reason for the state's success in this area. According to Cindy Lewis, a supervisor with the state Department of Health, Healthy Start was enacted by the Florida legislature in 1992. Similar to Massachusetts' program, Florida's Healthy Start is a comprehensive program that relies on a team of registered nurses and social workers to provide:

- care coordination
- home visits by a nurse and/or social worker
- nursing and developmental assessments
- parent education and support
- nutrition education/counseling
- smoking cessation counseling
- education materials pertaining to prenatal care, birth and infant care
- information and referral to other community services and programs
- psychosocial assessments

Services are provided in a clinic or in the mother's home. The purpose of Healthy Start, according to the Florida Department of Public Health web site, is to prevent low birth-weight babies, reduce the number of fetal and infant deaths and help high-risk pregnant women and infants access needed services before greater problems arise. It seeks to minimize economic, social and geographic barriers to health care. Healthy Start is a consensual program only, notes the web site information. Families must consent to services before they can be provided.

Lewis points to three legislative initiatives that may have had a positive impact on reducing babies born with one of the four risk factors. First, the legislature in 1992 created universal prenatal and infant screening, part of Healthy Start. Second, the legislature called for a system of prenatal care that was coordinated statewide but stressed local case management. Finally, Lewis cites Healthy Start's creation of 30 coalitions active around the state. These coalitions, based on county boundaries, have authority over directing funding and they often leverage their grants or find matching dollars to meet the unique needs of their community. Lewis added that the state provides technical assistance, oversight of the coalitions and quality assurance within the Health Department.

What is the National Education Goals Panel?

The National Education Goals Panel is a unique bipartisan body of state and federal officials created in 1990 by President Bush and the nation's Governors to report state and national progress and urge education improvement efforts to reach a set of National Education Goals.

Who serves on the National Education Goals Panel and how are they chosen?

Eight governors, four state legislators, four members of the U.S. Congress, and two members appointed by the President serve on the Goals Panel. Members are appointed by the leadership of the National Governors' Association, the National Conference of State Legislatures, the U.S. Senate and House, and the President.

What does the Goals Panel do?

The Goals Panel has been charged to:

- Report state and national progress toward the National Education Goals.
- Work to establish a system of high academic standards and assessments.
- Identify promising and effective reform strategies.
- Recommend actions for state, federal and local governments to take.
- Build a nationwide, bipartisan consensus to achieve the Goals.

The annual Goals Report and other publications of the Panel are available without charge upon request from the Goals Panel or at its web site www.negp.gov. Publications requests can be made by mail, fax, or e-mail, or by Internet.

An emerging issue, according to Lewis, is unfunded prenatal care for the growing number of undocumented citizens, who currently depend on emergency care for prenatal and childbirth healthcare. State officials are engaged in better defining the problem and seeking programs and policies to address the issue.

CONTACT: Cindy Lewis
Executive Community Health Nursing Director
Community and Child Health
Department of Health
Bin A-13 4052 Vald Cypress Way
Tallahassee, Florida 32399-1723
(850)245-4465

Connecticut

In 1997, Connecticut was the nation's top-performing state, having the lowest percentage of infants born with one or more of four health risks. Only 24% percent of infants were born with one or more of the four health risks, with the nationwide average at 33 percent.

Like Massachusetts and Florida, Healthy Start is cited as the program that focused the state's attention on prenatal care issues. The goal of Connecticut's Healthy Start program, according to Lisa Davis, supervising nurse consultant with the state Department of Health, is to improve access and availability to comprehensive health and health-related services to eligible pregnant women and children that contributes to the reduction of infant mortality and improved health status of children. Services provided by Healthy Start include:

- case identification – including door-to-door-visits and media campaigns
- needs assessment – all clients receive a standard Healthy Start risk assessment to determine if the pregnant women are low, moderate or high risk.

Davis also points to the success of Healthy Choices for Women and Children (HCWC), a five year (1990-1995) demonstration project funded by the Center for Substance Abuse Prevention and the Connecticut Department of Public Health and Addiction Services. The City of Waterbury was the recipient. Since 1995, the program has been funded by the Connecticut Department of Public Health and based at the Waterbury Health Department.

RESOURCES

America's Kindergartners: Early Childhood Longitudinal Study, Kindergarten Class of 1998-1999. *(2000) U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics. Washington, D.C.* www.nces.gov.

Association of Maternal & Child Health Programs. 1220 19th Street NW. Suite 801. Washington, D.C. 20036. (202)775-0436. www.amchp.org.

Caring for Our Future: The Content of Prenatal Care. Public Health Service Expert Panel on the Content of Prenatal Care. (1989) Washington, D.C. U.S. Public Health Service.

Closing the Gaps: Strategies for Improving the Health of Massachusetts Infants. *(1985) Massachusetts Department of Public Health. Boston, Massachusetts.*

I Am Your Child. 1010 Wisconsin Avenue NW. Suite 800. Washington, D.C. 20007. (202)338-4385. www.iamyourchild.org.

National Education Goals Panel. 1255 22nd Street NW. Suite 502. Washington, D.C. 20037. (202)724-0015. www.negp.org.

Healthy Choices provides case management, case coordination, counseling, home visiting and parenting support to Waterbury residents who are low-income (Healthy Start eligible) pregnant women of any age who: have used alcohol and other drugs; have previously used alcohol or drugs during their current pregnancy; or whose partners presently abuse alcohol or drugs. The program is deemed highly effective and was selected as one of sixteen programs nationally as an Exemplary Prevention Program in 1995.

Pregnant teens are targeted in Connecticut's Adolescent Pregnancy Prevention/Young Parents Program (APP/YPP). Goals of the program include:

- healthy birth outcomes
- prevention of initial and repeat teen pregnancies
- encouraging young parents to complete school and become economically self-sufficientincrease community awareness about teen pregnancy and its prevention

Thirteen cites, including the cities of New London, Bridgeport and New Haven, receive funds from the State Department of Health, the federal government and private sources, under APP/YPP.

Lloyd Mueller, spokesman for the state Department of Public Health, explained that strong local efforts to improve access and utilization of prenatal care in cities such as Bridgeport, New Haven and Waterbury is a key reason Connecticut may boost such a low-percentage in babies born with one of the four health risks.

CONTACT: Lisa Davis
Supervising Nurse Consultant
Maternal and Child Health Unit
410 Capitol Avenue MS #11FHD
PO Box 340308
Hartford, Connecticut 06134-0308
(860)509-8074

Upcoming Goals Panel Events

September 19, 2000

The Goals Panel will conduct the third of its regional public hearings regarding best practices in helping all children reach high academic standards. The hearing will be co-hosted by Panel chair Gov. Tommy Thompson (R-WI) and Gov. Paul Patton (D-KY). It will be held at 1:30 PM at the Grady High School in Atlanta, GA., and will focus on new school structures associated with raising student achievement.

October 2, 2000

NEGP chair, Gov. Tommy Thompson, will hold the final field hearing in Chicago, IL. The hearing will include updates on school reform in Chicago and focus on the use of data and reporting to raise student achievement.